STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to treat residents with dignity for six of twenty nine alert and oriented residents (Resident #6, #9, #5, #8, #11 and #10) by failing to answer call bells and not providing Activities of Daily Living (ADL) care. The list of alert and oriented residents was provided by the facility. The findings included: 1. Resident #6 was admitted to the facility on 4/14/15 with diagnoses of stroke and hemiplegia affecting right side. The recent significant and clinical change Minimum Data Set (MDS) assessment dated 8/11/15 indicated Resident #6 was cognitively intact. The quarterly MDS dated 7/21/15 indicated Resident #6 had adequate vision and was always incontinent for bowel and bladder. An interview with Resident #6 on 9/30/15 at 10:50 AM revealed she was recording the date and length of time she had to wait before staff answered the call bell. On 9/16/15, Resident #6 had to wait for five hours, on 9/20/15, Resident #6 had to wait for two and half hours, on 9/23/15, Resident #6 had to wait for two hours. Resident #6 further indicated sometimes the Nurse Aid (NA) came in the room, turned off the call bell and said they would be right back but did not come back for two hours. Resident #6 indicated	F 241	F241 Dignity and Respect of Individuality For those individual residents, Residents #6, #9, #5, #8, #11, and #10, based on resident interview a concern form has been generated for each individual. Each resident continues to reside at facility. Because all residents have the potential to be affected by the cited deficiency, a resident representative interviewed all alert and oriented residents for any dignity issues or concerns they might have. Based on individual resident concerns, staff education is being provided by an administrative nurse regarding caring for residents in a manner and environment that would maintain or enhance each resident¿s dignity and respect with regard to call light response and assistance with ADL¿s. Measures to ensure the deficient practice will not occur include a resident interview monitoring tool to ask alert and oriented residents how they feel they are being treated, if they feel they are getting the assistance needed with ADL¿s and if they feel their call light is being answered	10/26/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 sometimes the nurse aids put a new brief on and did not clean or wipe her off. Resident #6 stated she had appointment on 9/23/15 and she had an accident in her brief, she reported to her nurse and it was 25 minutes before an NA cleaned her. Resident #6 stated " It makes me feel bad, it is dirty and filthy to sit in it until they come." 2. Resident #9 was admitted to the facility on 1/21/15, with diagnoses of hypertension, overactive bladder and neuromuscular dysfunction of bladder. Review of Resident #9 ' s quarterly MDS assessment dated 7/31/15 indicated Resident #9 was cognitively intact with adequate vision. Resident #9 required extensive assistance for toileting with the use of one staff person. The MDS further coded Resident #9 as always being incontinent of bowel and had a urinary catheter. An interview with Resident #9 on 9/30/15 at 9:45 AM revealed last week she had to wait for almost seven hours to be cleaned up from bowel movement after using call bell. On 9/28/15, she had to wait for four hours before staff came to clean her up. Resident #9 indicated staff would turn off resident's call bell, then tell her that they would come back and they would not return for hours. On 10/1/15 at 12:05 PM Resident #9 further indicated on 9/30/15 at 9:30 PM, she told an NA she needed to be changed, but the NA did not come back, then the third shift NA after 11:00 PM changed her. On 10/1/15, Resident #9 asked to be changed at 8:20 AM that same morning and NA reported to the resident she would be back, but had not come back since then. Resident #9 stated " It is frustrating I even reported problem to administration but nothing has been changed. "	F 241	timely. Additional measures include call bell observations at various times across all three shift by a resident representative to monitor timely call light response. Corrective actions will be monitored by resident interview monitoring tool for affected individuals 3 times per week for four weeks then weekly for four weeks then monthly for 3 months. Resident interview monitoring tool for random alert and oriented residents 3 times per week for four weeks then weekly for four weeks then monthly for 3 months. Call light response audits will be conducted 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. The monitoring results will be brought to the Quality Assurance & Performance Improvement monthly meeting for further review, analysis, corrective action and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2	F 241		

3. Resident #5 was admitted to the facility on 8/26/15 with diagnoses of heart failure, diabetes and pain. A review of Resident #5's medical record revealed a 30 day MDS assessment dated 9/23/15 which indicated Resident #5 was cognitively intact and had adequate vision. Resident #5 was coded extensive assistance with ADLs with the use of two persons. The MDS further coded Resident #5 as being occasionally incontinent of bladder and always incontinent of bowel.

Resident #5 's room was observed on 9/30/15 at 10: 15 AM, call bell was flashing over the door, and staff entered the resident ' s room and stated she would send the NA. A nurse entered the resident ' s room, stated he would send the NA. A nurse and the NA came back to the resident ' s room and NA stated she would be back with gloves. The NA came back and helped resident. An interview with Resident #5 on 9/30/15 at 10:15 AM revealed she had the call bell on since 9:30 AM. Resident #5 stated the nursing staff would come by the room and turn off the call light and stated they would return and they did not come back and she had to wait for one and half to two hours. Resident #5 stated " I felt bad when I had to wait long. "

4. Resident #8 was admitted to the facility on 3/22/15 with diagnoses of hypertension, diabetes, and neuromuscular dysfunction of bladder. A review of Resident #8's quarterly MDS assessment dated 8/25/15 indicated Resident #8 was cognitively intact and had adequate vision. Resident #8 required extensive assistance for toileting with the assist of two staff persons. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241		

MDS further coded Resident #8 as always being incontinent of bladder and bowel. An interview with Resident #8 on 9/30/15 at 9:30 AM, revealed NA's would come by the room and turn off the call light and tell her they would return but they did not come back and Resident #8 had to wait for hours for any ADLs. On 10/1/15 at 12:10 PM Resident #8 further stated, " It feels like no one cares, it is really annoying."

5. Resident #11 was originally admitted to the facility on 3/28/14 with diagnoses of hypertension, anemia, and heart failure. Review of Resident #11 ' s quarterly MDS assessment dated 8/20/15 indicated Resident #11 was cognitively intact and had adequate vision. Resident #11 required extensive assistance for toileting with one staff person. The MDS further coded Resident #11 as being frequently incontinent of bladder and always incontinent with bowel. An interview with Resident #11 on 9/30/15 at 10:30 AM, revealed he had to wait for 30 minutes or more for a nurse aid to come and help him after he used the call bell. Resident stated " I do not like that I have to wait all that time. "

6. Resident #10 was admitted to the facility on 7/6/12, with diagnoses of hypertension, and hyperlipidemia. Review of Resident #10 ' s annual MDS assessment dated 7/2/15 indicated Resident #10 was cognitively intact and had adequate vision. Resident #10 required extensive assistance for toileting with one staff person. The MDS further coded Resident #10 as being occasionally incontinent of bladder. An interview with Resident #10 on 9/30/15 at 2:50 PM revealed average call bell response time would be 30-40 minutes for any care, and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 especially had to wait a long time during 3:00 - 11:00 PM shift. Resident #10 stated "No one cares, they need more staff and help." On 9/30/15 at 11:36 AM, in an interview NA #1 stated, she typically had 13-14 assigned residents, usually there were three NAs assigned to the hall but four NAs for that hall would be better. NA #1 further stated she could get to her incontinent care with the residents but had trouble with residents who had to go for dialysis or other appointments and needed to get cleaned up. Interview with NA #2 on 9/30/15 at 11:45 AM, stated on her hall they had 47 residents and three NAs were assigned to the hall but needed more help for the resident' s care. At 11:28 AM on 10/1/15, in an interview, NA #3 stated the facility needed more staff, one more NA for the hall would be better to get resident ' s care done, and residents would not feel like they were neglected. At 11:33 AM on 10/1/15, in an interview, NA #4 stated the residents were more dependent and needed more help, so one more NA on the hall would give more relief. In an interview on 10/1/15 at 1:00 PM, the Administrator revealed her expectation for call bell response time should not be 30 minutes or hours, and her expectation was for NAs to leave the resident' s call lights on until they could actually provide the assistance requested and for NAs to work together. The administrator further stated she was in the process of hiring more staff.	F 241		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	Continued From page 5 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to update a care plan for one of seventeen residents reviewed for care plans (Resident #1). Resident #1 was admitted 3/21/15 with diagnoses of stroke with some paralysis on the right side, diabetes and depression. The quarterly Minimum Data Set (MDS) dated 7/14/15 noted Resident #1 was cognitively impaired and needed limited assistance for eating with one person ' s physical assistance. Limited	F 280	F280 Right to Participate Planning Care-Revise CP For individual resident #1 the care plan has been reviewed and updated to reflect his current level of assistance needed with meals. Because all residents have the potential to be affected by the cited practice, all residents care plans have been reviewed and updated as needed for current level of assistance needed for meals. Measures to ensure communication of resident changes needing to be reflected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6 assistance means the resident is highly involved in the activity and the staff is providing guidance. A list of residents who needed feeding assistance was reviewed and revealed Resident #1 was on this list. The care plan dated 3/31/15 noted a focus of an Activities of Daily Living (ADL) self-care performance deficit. The goal was that Resident #1 would improve the current level of functioning through the next review date. The interventions listed under eating were the resident is able to feed self with set up. Resident #1 was observed being fed by staff on 9/30/15 at 8:15 AM and again on 10/1/15 at 8:30 AM. On 10/1/15 at 11:55 AM in an interview, the MDS coordinator stated Resident #1 was feeding themselves in July when the MDS was updated. The documentation by the Nurse Assistant (NA) was reviewed for July and noted Resident #1 was feeding himself. The documentation for September indicated Resident #1 was being fed. The MDS coordinator said " we missed that, we need to look at him again " . On 10/1/15 at 12:50 PM in an interview, the administrator stated the expectation was the care plans would be updated in a timely manner.	F 280	on resident care plan to the MDS department will be review of the 24 hour report sheets and any new orders by a member of the MDS department in addition to IDT morning meeting clinical discussion. Corrective measures will be monitored through audits performed by the MDS supervisor weekly for 4 weeks then every 2 weeks for 4 weeks then monthly for 3 months. The monitoring results will be brought to the Quality Assurance & Performance Improvement monthly meeting for further review, analysis, corrective action and recommendations as needed.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to provide incontinent care or toileting for six of twenty nine residents interviewed that needed extensive to total assistance for Activities of Daily Living (ADL) care (Residents #5,6,7,8,9,10). Findings included: 1. Resident #6 was admitted 4/14/2015 with diagnoses of stroke and hemiplegia affecting the right side. The quarterly Minimum Data Set (MDS) dated 7/21/15 noted Resident #6 to be always incontinent for bowel and bladder. The MDS noted Resident #6 had adequate vision. The change of therapy MDS dated 8/11/2015 noted the resident to be intact for cognition and needed extensive assistance for all ADLs with the physical assistance of one person for toileting On 9/30/2015 at 10:40 AM, Resident #6 stated whether she was just wet or had a bowel movement, she had to wait on staff to come to change her. Resident #6 stated she had recorded wait times in her phone. The resident specified she had to wait for greater than two hours to be changed by staff on 09/16/2015, 09/20/2015 and 09/23/2015. Resident #6 also stated that on 9/24/2015 the call bell was on, the Nurse Aide (NA) came into the room, turned off the call bell and said " I ' ll be back " and did not return for 2 hours. Resident #6 stated she had called the Administrator to tell her she was having to wait, but nothing came of it. Resident #6 stated she had spoken to the Physician ' s Assistant (PA)	F 312	F312 ADL Care Provided For Dependent Residents For those individual residents, Residents#5, #6, #7, #8, #9, and #10, a concern form has been generated for each individual based on resident interview. Each resident continues to reside at the facility. Because all residents have the potential to be affected by the cited deficiency, a resident representative interviewed all alert and oriented residents for any toileting issues or concerns they might have. Based on individual resident concerns, staff education is being provided by an administrative nurse regarding caring for residents who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene with regard to call light response and assistance with ADL¿s. Measures to ensure the deficient practice will not occur include a resident interview monitoring tool to ask alert and oriented residents how they feel they are being treated, if they feel they are getting the assistance needed with ADL¿s and if they feel their call light is being answered timely. Call bell observations across all three shifts at various times by a resident representative to monitor timely call bell	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 about having to wait and the PA had filed a concern form. Resident #6 stated when she had to lay in stool and wait for someone to clean her, she felt " dirty, filthy " such a bad feeling. A review of the concern form revealed it was written and signed by the PA on 9/25/2015 and stated that Resident #6 had stated she had been waiting 3+ hours for the call bell to be answered. The Administrator had NAs write their statements on a separate sheet of paper, which was attached to the concern form. On 10/1/15 at 12:50 PM, in an interview, the Administrator stated she did have a staffing problem at times, and she stated the investigation into the concern filed by the PA was ongoing. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire. On 9/30/2015 at 11:45 AM an observation was made of incontinent care for Resident #6. Care was provided with clean and appropriate technique. On 9/30/2015 at 11:55 AM, an interview was conducted with NA #2 who provided care to Resident #6 on a regular basis. NA #2 stated that Resident #6 was dependent on staff for care. NA #2 further stated she did not believe there were sufficient nursing assistants available to care for the resident population on the 300 hall. NA #2 noted there were a total of 47 residents that resided on the 300 hall and it was difficult to get all resident care completed on time when there were only three NAs working on the hall. On 10/1/15 at 12:50 PM, in an interview, the	F 312	response. Corrective actions will be monitored by resident interview monitoring tool for affected residents 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. Resident interview monitoring tool will be completed on random alert and oriented residents 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. Call bell observation will be completed across all three shifts at various times 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. The monitoring results will be brought to the Quality Assurance & Performance Improvement monthly meeting for further review, analysis, corrective action and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9	F 312		

Administrator stated she did have a staffing problem at times. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire.

2. Resident #9 was admitted 1/21/2015 with diagnoses of overactive bladder and neuromuscular dysfunction of bladder. The quarterly MDS dated 7/31/2015 noted Resident #9 was cognitively intact and needed extensive assistance for toileting with the physical assistance of one person. The MDS further noted Resident #9 was coded as being always incontinent of bowel and having a urinary catheter.

On 9/30/15 at 9:45 AM, in an interview, Resident #9 stated last week, after turning on the call bell, she waited 7 hours to be cleaned after a bowel movement. Resident #9 stated on 9/28/15 she waited 4 hours for staff to clean her up. Resident #9 indicated that staff would come into her room when the call bell was on, turn it off and say that they would be back, but would not return for hours. In an interview on 10/1/15 at 12:05 PM, Resident #9 noted she had reported the problem of having to wait on the call bell to be answered to the Administrator, but nothing had been done. Resident #9 had told the NA on 9/30/15 at 9:30 PM, she needed to be changed, but the NA did not come back. Resident #9 stated that when the 11:00PM -7:00 AM shift came on, an NA from that shift changed her. During the interview, Resident #9 stated she had asked to be changed at 8:20 AM, the NA said that she would be back, but had not returned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10	F 312		

On 10/1/2015 at 11:55 AM, NA #4, who worked on the facility ' s 200 hall where Resident #9 resided, stated she felt the facility was short staffed. NA #4 said " I have told the Director of Nursing and she has said they are trying " .

On 10/1/15 at 12:50 PM, in an interview, the Administrator stated she did have a staffing problem at times, and she knew about the second shift NA #5 not changing Resident #9. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire.

Staffing sheets for 9/30/2015 and 10/1/2015 were reviewed and revealed there were 3 NAs scheduled for the 200 hall and 300 hall for both days. The 200 hall for the 3:00 PM to 11:00 PM shift only had 2 NAs for the entire shift and 1 NA working from 7:00 PM to 11:00 PM.

3. Resident #5 was admitted 8/26/2015 with diagnoses of diabetes, heart failure, pain, and edema. The 30 day Minimum Data Set (MDS) dated 9/23/2015 noted the resident to be cognitively intact and needed extensive assistance for all ADLs, with the physical assistance of two persons. The MDS noted Resident #5 to be occasionally incontinent of urine and always continent of bowel. Resident #5 was also coded as having adequate vision without corrective lenses.

An observation was made of Resident #5 ' s room on 9/30/2015 at 10:15 AM. The call bell outside the room was flashing and the bell was sounding. A staff member entered the room and left the door ajar, then came to the door and looked back and told the resident that she would find the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 11	F 312		

resident ' s Nurse Assistant (NA). Upon entering the room Resident #5 stated that she had turned the call bell on at 9:30 AM. As soon as the resident made this statement a nurse came into the room and asked if he could help because he saw the call light on. Resident #5 stated that she had to go to the bathroom. The nurse indicated that he would find her NA and he left the room. NA #6 did come into the room, stated she had to get gloves because the glove box on the wall was empty, and she would return. Resident #5 stated this happens all the time, and she has waited 1 ½ hours in the past. Resident #5 stated that she felt so bad when she had to wait. NA #6 did return and assisted Resident #5. When NA #6 returned she stated " This is a crazy day! "

On 9/30/2015 at 11:15 AM, NA #6, who provides care on the 300 hall for Resident #5 stated that she feels there is usually enough staff to give care to the residents on the 300 hall. NA #6 stated she had been busy in another room when Resident #5 needed assistance during the morning of 9/30/2015.

On 9/30/2015 at 11:45 AM, the Administrator stated there was a staffing shortage at times. When informed as to what had occurred in Resident #5 ' s room, the Administrator stated that the first staff member in the room could have assisted Resident #5 to the bathroom. The Administrator indicated she was looking to hire additional staff.

4. Resident #8 was admitted on 3/22/2015 with diagnoses of chronic kidney disease, heart failure and diabetes.
The quarterly MDS dated 8/25/2015 noted Resident #8 was cognitively intact and needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 12	F 312		

extensive to total assistance for ADLs with the physical assistance of two persons. The MDS noted Resident #8 was always incontinent for bladder and bowel.

On 9/30/2015 at 9:30 AM Resident #8 stated she must wait a long time for the call bell to be answered for incontinent care, sometimes it was hours and nights and evenings were worse. Resident #8 also indicated the NAs would come in and say they would be back, but did not come back for hours. Resident #8 stated that she hardly ever got a bath on time.
On 10/1/2015 at 12:10 PM Resident #8 stated she likes to have ice, but rarely gets ice. Resident #8 stated she had asked for ice so many times and no one brings it. Resident #8 stated when the call bell was not answered for a long time, she felt frustrated and that no one cared.

On 9/30/2015 at 11:36 AM NA #1, who was working on the 200 hall and usually provided care for Resident #8, was interviewed and she stated there was not enough staff for the 200 hall. NA #1 indicated she could get to her incontinent residents but had trouble with the residents who had to go to dialysis or to appointments and needed to get cleaned up.

On 10/1/15 at 12:50 PM, in an interview, the Administrator stated she did have a staffing problem at times. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire.

5. Resident #10, who resided on the facility ' s 200 hall, was admitted 7/6/2012 with diagnoses of hemiplegia, depression and aphasia. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13	F 312		

annual MDS dated 7/2/2015 noted Resident #10 was cognitively intact and needed extensive assistance for all ADLs with the physical assistance of one person for toileting and personal hygiene. The MDS coded Resident #10 as always continent for bladder and as having an ostomy.

On 9/30/2015 at 2:50 PM Resident #10 stated when he needed assistance to the bathroom, call bell response time was at least 30 - 40 minutes, sometimes care was not given and there was no particular day that was worse. Resident #10 noted the care was mostly delayed on the 3:00 PM to 11:00 PM shift. Resident #10 stated that no one cared.

On 10/1/2015 at 11:28 AM, NA #3, who regularly provided care to Resident #10, stated she felt the facility was short staffed. NA #3 indicated the aides tried to work together if the staffing was short and the residents were told so they were aware and didn ' t feel neglected. NA #3 indicated that staffing had been better over the past two weeks, but 4 NAs were needed on the hall (200 hall) for the best care. NA #3 noted there had never been a time when there were 4 NAs, but there had been a time when there were only 2 NAs caring for the 200 hall residents, which would certainly slow the call bell response by the staff.

On 10/1/15 at 12:50 PM, in an interview, the Administrator stated she did have a staffing problem at times. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 14 6. Resident #7 was admitted 12/25/2011 with diagnoses of end stage renal disease, dialysis, congestive heart failure, diabetes and aphasia following a stroke. The quarterly MDS dated 8/3/2015 noted Resident #7 to be cognitively intact and needed extensive assistance with all ADLs with the physical assistance of one person. The MDS also coded Resident #7 as being occasionally incontinent of bladder and frequently incontinent of bowel. On 9/30/15 at 9:12 AM Resident #7 stated that she did not get her bath on time and that she needed assistance to the toilet and sometimes had to wait more than 30 minutes for her call bell to be answered. Resident #7 stated that what bothered her most was getting her bath late. On 9/30/2015 at 11:36 AM NA #1, who was working on the 200 hall, was interviewed and she stated there was not enough staff for the 200 hall. NA #1 indicated she could get to her incontinent residents but had trouble with the residents who had to go to dialysis or to appointments and needed to get cleaned up. On 10/1/2015 at 1:00 PM, the Administrator stated her expectation for call bell response should be " as needed " and the NAs should not turn the call bell off and leave the room. The Administrator stated she had hired more staff.	F 312		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as	F 353		10/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 15 determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide sufficient staff to give adequate Activities of Daily Living (ADL) care for 2 of 2 residents (Resident #7 and Resident #13) for bathing, and 6 of 8 residents (Residents #5,6,7,8,9,10) for incontinent care. Findings included: 1.This citation is cross referenced to F312 - Based on observation, staff and resident interviews and record review, the facility failed to provide incontinent care or toileting for six of twenty nine residents interviewed that needed extensive to total assistance for Activities of Daily Living (ADL) care (Residents #5,6,7,8,9,10). 2.This citation is cross referenced to F241 -	F 353	F353 Sufficient 24-hr Nursing Staff per Care Plans Citation is cross referenced to F312 and F241 For those individual residents, Residents#5, #6, #7, #8, #9, #10, #11 and #13, a concern form has been generated for each individual based on resident interview and each continues to reside at facility. Because all residents have the potential to be affected by the cited deficiency, a resident representative interviewed all alert and oriented residents for any ADL assistance issues or concerns they might have.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 16 Based on record review and resident and staff interviews the facility failed to treat residents with dignity for six of twenty nine alert and oriented residents (Resident #6, #9, #5, #8, #11 and #10) by failing to answer call bells and not providing Activities of Daily Living (ADL) care. The list of alert and oriented residents was provided by the facility. Resident #16 was admitted 7/28/2015 with diagnoses of Multiple Sclerosis, Urinary Tract Infection, arthritis and depression. The admission Minimum Data Set (MDS) dated 8/4/2015 noted Resident #16 to be cognitively intact and needed extensive assistance for all ADLs with the physical assistance of one to two persons. On 10/1/2015 at 9:00 AM, in an interview, Resident #16 stated that she had attended the September 17, 2015 Resident Council meeting, which was held in the facility monthly. Resident #16 noted the Director of Nursing (DON) and the Administrator of the facility were also at the meeting. Resident #16 stated that the group expressed their concerns regarding the facility being short staffed and the long call bell response times. Resident #16 noted after the meeting there were no changes and no resolution to the Resident Council concerns. A review of the Resident Council Meeting minutes for July 23rd, August 20th, and September 17th, 2015 revealed there were concerns regarding staffing at all three meetings. On 10/1/2015 at 9:30 AM, in an interview, the Administrator stated she attended the September 17, 2015 meeting of the Resident Council and noted the DON told the residents there were staff	F 353	Based on individual resident concerns, staff education is being provided by an administrative nurse regarding providing nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and individual plans of care with regard to call light response and assistance with ADL¿s. Measures to ensure the deficient practice will not occur include a resident interview monitoring tool to ask random alert and oriented residents how they feel they are being treated, if they feel they are getting the assistance needed with ADL¿s and if they feel their call light is being answered timely. Call bell observations across all three shifts at various times by a resident representative to monitor timely call bell response. Corrective actions will be monitored by resident interview monitoring tool for affected residents 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. Resident interview monitoring tool will be completed on random alert and oriented residents 3 times per week for 4 weeks then weekly for 4 weeks then monthly for 3 months. Call bell observation will be completed across all three shifts at various times 3 times per week for 4 weeks then weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 17 that were not NAs that helped out doing care. The Administrator stated that she was working on the problem of not having enough NAs available to provide care and was looking for staff to hire. 3. Resident #7 was admitted 12/25/2011 with diagnoses of end stage renal disease, dialysis, congestive heart failure, diabetes and aphasia following a stroke. The quarterly MDS dated 8/3/2015 noted Resident #7 to be cognitively intact and needed extensive assistance with all ADLs with the physical assistance of one person. The MDS also coded Resident #7 as being occasionally incontinent of bladder and frequently incontinent of bowel. Resident #7 was also coded for having adequate vision without corrective lenses. On 9/30/15 at 9:12 AM, in an interview, Resident #7 stated that she did not get her bath on time and it seemed to take all day to get her bath. Resident #7 stated she went to dialysis Tuesday, Thursday and Saturday but the staff could not get her bath done before she goes to dialysis. Resident #7 noted she needed assistance to the toilet and sometimes had to wait more than 30 minutes for her call bell to be answered. Resident #7 stated that what bothered her most was getting her bath late. On 9/30/2015 at 11:36 AM NA #1, who was working on the 200 hall, was interviewed and she stated there was not enough staff for the 200 hall. NA #1 indicated she could get to her incontinent residents but had trouble with the residents who had to go to dialysis or to appointments and needed to get cleaned up. 4. Resident #13 was admitted 7/31/2015 with	F 353	for 4 weeks then monthly for 3 months. The monitoring results will be brought to the Quality Assurance & Performance Improvement monthly meeting for further review, analysis, corrective action and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 18 diagnoses of anxiety, depressive disorder and slow transit constipation. The admission MDS dated 8/10/2015 noted Resident #13 to be cognitively intact and needed extensive assistance for al ADLs with the physical assistance of one person. On 9/30/2015 at 10:35 AM, Resident #13 stated he is supposed to get a shower on the 3:00 PM - 11:00 PM shift. Resident #13 stated the night before (9/29/2015) he was told his shower would be at 10:00 PM or 10:30 PM and he told the NA that he could not sit up that long to wait for a shower, so he went to bed. Resident #13 stated he knew it would not happen earlier because there were only 3 NAs for the entire 300 hall.	F 353		